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Special Communication

Babel in Medicine?

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THERE HAS BEEN a general decline in the quality of medical speech; it has become a jargon laced with abbreviations, acronyms, slang expressions and unintelligible word contractions. Although the burgeoning medical technology is partly to blame, physicians' disrespect for grammatical and linguistic purity is principally responsible for this degenerative trend in everyday medical speech.

Babel rose when the "whole earth was one language." Babel fell when the Lord confounded language so that the people did not understand one another's speech. The language of today's medical speech has now become such a jumble of jargon, slang and dialect that the specter of Babel is now upon us.

The meteoric rise of medical technology is one of the forces behind the degenerative trend of endlessly proliferating acronyms and abbreviations. Is another force the degradation of the central character of the medical drama, the beleaguered patient, abed amidst a bewildering array of technologic weapons against disease? Have we dehumanized him to the point where instead of a whole human being he is an organ, a disease, an operation, a bed or a room?

I have noted the creeping corruption of our language with dismay, and to document its decline and fall, I have gathered some "true to life" expressions from just a few weeks of bedside rounds. The following skit is merely an illustrative sample, not at all an inclusive portrayal. Unabridged, it could be expanded to a full length play, comic in one sense, but tragic in another.

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Rounds With the Chief
or
Requiem for a Noun

The Time: 7:30 AM. Now, Yesterday or Tomorrow

The Place: Megalo Medical Center, Anywhere, USA

The Characters: Chief of Service (C of S)
Five residents (R-5, R-4, R-3, R-2, R-1)

R-5: Hey, here comes the old man . . . Hi Chief!

C of S: Good morning, gentlemen. You all look fine this morning. Shall we begin?

R-5: OK. Our first patient is an appy. Came in at 3:00, pre-opped by 3:30. R-4 had him in the OR by 4:00. Do you want to describe your findings, R-4?

R-4: Nothing to add. It was an acute AP. We did it through a McBurney. We'll keep him NPO today.

C of S: Hmmmm.

R-5: Next is the gallbladder. Came in jaundiced day before yesterday. The labs are not back yet but she's had ultrasound, a CT scan, T99 Pepida and we're considering ERCP or PCT . . . .

C of S: What's the color of her stool?

R-1: We haven't gotten around to a rectal yet.

C of S: Hmmmm.

R-5: Anyway, we decided to sit on her before cholecystectomizing her. She's being worked up. Maybe we can get her on for tomorrow.

C of S: Hmmmm. Say, that patient who just walked by looks familiar. Do I know her?

R-5: That's the breast, Chief, modified radical for CA. Two positive nodes so she'll have an onco consult and be seen by radiation therapy. Hemovac is out and flaps are fine.

C of S: Hmmmm.

R-5: Our next patient is a spleen being worked up for possible splenectomy. Hematocrit was 20 so we're transfusing him up. Tentative diagnosis is myelofibrosis. Bone marrow is cooking.

C of S: Hmmmm.

R-5: Next is a trauma victim brought into the ER at 4:00 AM. R-2 will give the details.

R-2: This fella was an auto versus auto. Head injury, facial lacerations, fractured ribs, hemothorax, blunt abdominal trauma and bilateral hips. He was seen by neuro, plastic, chest, ortho, uro, and finally we were called. He had a board-like belly. We tapped him and got blood, so we opened him up after he was volume resuscitated. We couldn't find the source. He's a little antsy this morning but his vitals are OK and his crit is stable.

R-5: What does the neurosurgeon say about his head trauma?

R-2: He's waiting for the EMI.

C of S: Has the family been in?

R-2: We didn't ask. All this guy asked about was his Porsche. It was totaled.

R-5: Our next patient is a real puzzler. He presented with a mass in the neck which we biopsied yesterday but the path isn't back yet. We might get him on for Tuesday.

C of S: On what?

R-5: On the schedule, Chief. It's pretty tight these days. . . . The inflammatory bowel disease is in the next bed. She's on hyper-al and we're waiting for GI to see her. She's ambulating to the bathroom and all her labs are on the money. GI might scope her today, but if they don't, we might want to get a gastrograffin on her.

C of S: Hmmmm. Well, that's about all I have time for today. I'm 15 minutes late for my committee meeting. Looks like an interesting service. Keep that census up. Thank you.

Residents:

Thank *you,* Chief.

[*All yawn in unison*]

But let us now remove tongue from cheek to articulate a plea. The supplication is to teachers and students alike.

There has been a spate of articles[1-3] and books[4,5] on proper medical writing. Few exist for ordinary medical parlance.[6] Pleas have been made to have English as the lingua franca of the medical world, particularly with the richness of Greek and Latin terms which lend it a universality found in few other languages. But if we persist in the bastardization of the language, there will be no lingua franca for us, no "one language for the whole earth."

Teachers as well as students are the keepers of the flame. Living languages must change, but not for the worse. Babel is upon us. Let us return to the principles of clarity, accuracy and grammatical purity.

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